

THE LIEUTENANT GOVERNOR'S OFFICE ON AGING
Geriatric Loan Forgiveness Program Application

Applicant Name:					
Address:					
City/Town:		State:		Zip:	
Telephone Number:					
E-mail Address:		SSN:			

Geriatric Specialty: ☐ Geriatrician ☐ Geropsychiatry

Location of Practice or Intended Location of Practice:					
Medical School:					
Internship/Residency and Specialty:					
Fellowship:					

Lender Name:					
Contact Person:					
Address:					
City:		State:		Zip:	
Phone Number:					
Loan Balance:					

Attach Copy of Loan and a copy of Resume

List Three (3) References:

Name:		Phone Number:			
Address:					
City		State:		Zip:	
Relationship:					

Name:		Phone Number:			
Address:					
City		State:		Zip:	
Relationship:					

Name:		Phone Number:			
Address:					
City		State:		Zip:	
Relationship:					

I do hereby certify that all information provided in this application and the attachments is complete and accurate. Submission of this application gives my consent for the Lt. Governor's Office on Aging (LGOA) to contact my loan company for verification of loan balance and payment if I am a chosen applicant and have signed the contract with the LGOA. I understand that false statements or information are punishable by federal law. I have read and understand this statement.

Applicant Signature: _____ Date: _____

Return Application To:

Eve B. Barth, MHA
Program Manager
Geriatric Loan Forgiveness Program
1301 Gervais Street, Suite 200 * Columbia, South Carolina 29201

SC Geriatric Loan Forgiveness Program

APPLICATION INSTRUCTIONS

Applicants should complete the application and submit with attachments to the Lt. Governor's Office on Aging by 4:00pm, January 22, 2008. Only complete applications will be considered. A complete application will include items 1 through six listed below:

1. A completed *Geriatric Loan Forgiveness Application*
2. A letter of request that includes the following:
 - Statement of need for loan repayment;
 - Statement of intent to open and maintain a practice in the field of Geriatric Medicine or Geriatric Psychiatry in South Carolina, for no fewer than five consecutive years, immediately following completion of your fellowship;
 - Statement of intent to continue to practice in SC at the completion of the five-year commitment;
 - Statement of intent that 60% of patients in the practice will be Medicare recipients age 60 or older;
3. A Statement from student loan company(s) showing the current loan balance
4. Three letters of reference in sealed envelopes
5. A resume
6. A copy of the Geriatric Fellowship Certificate or proof of Geriatric Medicine or Geriatric Psychiatry Fellowship if the Fellowship has not yet been completed
7. If applicant would like to be considered a 'SC native', as defined below, please include documentation.

All documents will be presented to the Physician Advisory Board for consideration. Interviews will be scheduled with applicants and members of the Advisory Board on **February 20, 2008**. A letter of acceptance or denial will be sent to the applicant within one week of the final decision.

In the event non-compliance is determined, the penalty, as stated by SC law, is three (3) times the total reimbursement received by the applicant plus interest at the prime rate plus ten percent calculated from the date non-compliance was determined.

Physicians chosen for this program must be willing to sign a contract agreeing to:

- Open and maintain a practice in the field of Geriatric Medicine or Geriatric Psychiatry in South Carolina, for no fewer than five consecutive years, immediately following completion of your fellowship;
- Become Board Certified in the field of Geriatric Medicine or Geriatric Psychiatry within one year of opening your practice;
- Accept patients 60 and older into your practice;
- Accept Medicare and Medicaid reimbursement;
- Not discriminate against patients based on ability to pay.

Priority will be given to applicants in the order listed below.

1. South Carolina native* who completes a fellowship in Geriatric Medicine or Geriatric Psychiatry from an accredited school of medicine in South Carolina.
2. Out-of-state applicant who completes a fellowship in Geriatric Medicine or Geriatric Psychiatry from an accredited school of medicine in South Carolina.
3. South Carolina native* who completes a fellowship in Geriatric Medicine or Geriatric Psychiatry from an accredited out-of-state school of medicine.
4. Out-of-state applicant who completes a fellowship in Geriatric Medicine or Geriatric Psychiatry from an accredited out-of-state school of medicine.

* South Carolina native is defined as an individual who was born in SC and continues to maintain a legal residence in SC or is an individual who has lived in SC for at least 15 years.

Once a decision is made and the contract is signed, payment(s) will be mailed directly to the applicant's loan company.

EEO DATA REPORTING FORM:

We ask that you provide the following information to be collected for statistical purposes only.
Refusal to answer will not result in adverse treatment of any applicant.

Today's Date:	/ /		
SSN:			
Last Name:		Middle:	
First Name:			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Birth:			
Race (check appropriate box)	1.	<input type="checkbox"/> American Indian/Alaskan Native	
	2.	<input type="checkbox"/> Asian/Pacific Islanders	
	3.	<input type="checkbox"/> Black/Non-Hispanic	
	4.	<input type="checkbox"/> Hispanic	
	5.	<input type="checkbox"/> White/Non-Hispanic	

Will you need reasonable accommodations to participate in the interview process (e.g. handicap accessible parking, etc.)

☐ Yes ☐ No